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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised copy of the deficiencies was sent to the provider on 10/29/13.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. Based on observation and interview, the facility failed to post the survey results in an area readily accessible to residents. Findings included: - An observation on 10/16/13 at 10:40 a.m. revealed a notebook with survey results located in the main entry in a clear hanging file approximately 5 feet high, not easily accessible to residents in wheelchairs. A coat rack located in front of the hanging file obstructed the view of the survey results.	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 167	Continued From page 1 During an interview on 12/21/13 at 3:24 p.m., administrative nurse A stated it would be difficult for a resident in a wheelchair to reach the survey results or to see the results with the coat rack in front of them. The facility failed to post the survey results in an area readily accessible to residents.	F 167		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents with 12 residents sampled for review and 1 resident sampled for physical restraints. Based on observation, interview, and record review, the facility failed to ensure 1 resident reviewed for physical restraints remained free of physical restraints not required to treat the resident's medical symptoms. (Resident #5) Findings included: - Resident #5's 8/29/13 signed physician's orders included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), history of a stroke (the sudden death of brain	F 221		

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cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), and osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).

Resident #5's 8/31/13 Quarterly MDS (Minimum Data Set) Assessment reported the resident understood others, made him/herself understood, and had severely impaired cognition. The resident needed limited assistance of one staff to transfer, move in bed, and for toilet use. He/she experienced balance problems in all areas and independently moved throughout the facility with a wheelchair or walker. The MDS reported that staff placed the resident on a toileting program as he/she always had urinary incontinence. The resident had no falls since the last assessment.

Resident #5's 6/10/13 Falls CAA (Care Area Assessment) summary reported the resident had a risk for falls due to a history of falls and he/she scored as high risk for falls on the facility's fall risk assessment. The CAA reported the resident propelled him/herself independently in a wheelchair throughout the facility and the resident's wheelchair had an automatic brake locking device to keep the wheelchair in place in case the resident stood from the wheelchair seat without assistance.

Resident #5's 6/12/13 care plan informed staff that the resident had a risk for falls due to cognitive impairment and history of falls. The care plan instructed staff that the resident propelled him/herself in a wheelchair. Interventions included providing moderate to maximum assistance with a gait belt while the

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resident transferred, ambulated with a walker, and toileted. Staff revised the care plan on 10/1/13 after the resident fell on 9/30/13 with an intervention that staff placed a lap table on the resident's wheelchair "per family request" and placed a gripper mat under the wheelchair pad to prevent the pad from slipping forward. Instructions related to the lap table on the care plan included removing the lap tray at meal times, during activities, and when going to bed.

Review of the resident's nurses' notes revealed on 9/30/13 at 7:25 p.m., staff found the resident on the floor at the east nursing station door laying with his/her legs straight out and his/her head against the wall.

A nurse's note on 10/1/13 at 10:30 a.m. documented that nursing staff discussed the fall with the resident's family member who requested that staff place a lap table on the resident's wheelchair to keep the resident from sliding out. Nursing staff explained the risks of using the lap tray and reported the family member signed a consent to use the lap table as a physical restraint.

Review of resident #5's clinical record revealed that Administrative Nursing Staff A assessed the resident's need for the lap table as a restraint on 10/1/13. The assessment reported that the resident could follow instructions at times, had impaired safety awareness, and needed minimal assistance of one or two staff with transfers. Staff A documented that the resident leaned forward in his/her wheelchair, wandered the hallways, and did not have restlessness. The assessment reported other measures attempted prior to use of the restraint as "repositioning".

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Staff A documented that the targeted behavior that necessitates use of a restraint as "the resident slid out of the wheelchair on 9/30/13..., does have anti-lock brakes on the wheelchair, the resident does stand up while in the wheelchair and can reposition self". The assessment documented that resident qualified as a candidate for a restraint alternative program.

Review of resident #5's physician's orders included a 10/1/13 order for a lap table to be on while the resident sat in the wheelchair to keep the resident from sliding out, to take off at meal times, check every 30 minutes, and release every 2 hours. The physician's order regarding the lap table restraint did not match the instructions on the care plan.

During an observation on 10/16/13 at 10:56 a.m., resident #5 propelled his/her wheelchair in the hallway with a lap table attached to the wheelchair arm rests and the resident wore sturdy shoes. Between 11:30 a.m. and 12:45 p.m., the resident sat at the dining table without the lap table attached to his/her wheelchair and continued to be monitored by multiple kitchen and direct care staff. Between 1:40 p.m. and 5:15 p.m., the resident laid in bed.

During an observation on 10/17/13 at 8:38 a.m., the resident sat in the wheelchair at the dining table without the lap table on his/her wheelchair. At 8:49 a.m., Direct Care Staff I placed the lap table on the wheelchair after the resident finished breakfast and the resident propelled him/herself in the hallway. At 9:00 a.m., Licensed Nursing Staff H stood close to the resident while the resident continued to propel him/herself in the wheelchair. At 9:20 a.m., DIrect Care Staff L

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released the lap table to assist the resident with restorative exercises. At 9:30 a.m., Staff L placed the lap table back on the wheelchair and propelled the resident to the dining room. At 10:00 a.m., resident #5 sat in his/her wheelchair with a lap table attached to the arm rests while in the dining area. Activity/Social Service Staff Q invited the resident to join a group activity at another dining room table and failed to remove the lap table during the activity as instructed in the resident's care plan.

During an interview on 10/16/13 at 2:00 p.m., Direct Care Staff M reported that staff only released resident #5's lap table at meal times and lacked awareness of any other instructions related to the lap table.

During an interview on 10/21/13 at 1:40 p.m., Licensed Nursing Staff H reported that after the resident fell, the resident's family member insisted that staff placed a lap table on the wheelchair to keep him/her from sliding out onto the floor. Staff H reported he/she did not think the lap table was an appropriate intervention for resident #5 to prevent further falls and stated the facility usually used restraints as a last resort. Staff H reported a lack of awareness how long the facility will continue to use the restraint or any plans to reduce the use.

The facility's 5/14/12 "Physical and Chemical Restraint Use" policy instructed staff that residents have the right to be free from physical restraints, that the facility is a restraint-free facility, and the use of physical restraints in the facility is prohibited.

The facility failed to ensure resident #5 remained

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F 221	Continued From page 6 free of physical restraints after he/she fell on 9/30/13 and initiated the use of a lap table without medical justification.	F 221		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The facility had 3 hallways with resident rooms. Based on observation, interview, and record review, the facility failed to maintain a sanitary and comfortable interior (dust accumulation on bathroom ceiling vents in 5 resident rooms on the east hallway and 1 resident room on the west hallway with gouges in the walls). Findings included: - Observations during stage one of the survey from 10/14/13 at 2:55 p.m. to 10/15/13 at 11:17 a.m. revealed 5 resident rooms on the east hallway had circular ceiling vents with dust accumulation in the bathrooms. An observation on 10/15/13 at 8:53 a.m. revealed a resident room on the west hallway with 2 large gouges in the wall approximately 6 inches by 6 inches near the entry below the light switch. The room also had gouges with chipped paint on the wall behind the resident's recliner.	F 253		

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F 253	Continued From page 7 During an interview on 10/18/13 at 11:05 a.m., maintenance staff D revealed that housekeeping staff cleaned the ceiling vents in the resident bathrooms. Staff D further stated that he/she repaired gouges once a year or when a resident moved out of a room and did not have a system in place to check for gouges in the walls. An interview on 10/21/13 at 8:20 a.m. with housekeeping staff E revealed housekeeping staff should clean the bathroom vents when cleaning the bathrooms daily. The facility's July 2013 Cleaning Policy directed housekeeping staff to clean the bathroom vents of resident bathrooms with each cleaning. The facility failed to maintain clean ceiling vents in resident bathrooms and repair gouges in walls in a resident room.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 39 residents with 12 residents sampled for review.

Based on observation, interview, and record review, the facility failed to review/revise 2 of the 12 residents' comprehensive care plans related to falls. (Residents #29 and 28).

Findings included:

- Resident #29's 9/9/13 signed physician's orders included diagnoses of arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and history of a stroke (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain).

Resident #29's 8/20/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident usually understood others, usually made him/herself understood, and had moderately impaired cognition. The resident independently moved in bed and throughout the facility with a walker or a wheelchair and needed limited assistance of one staff for transfers and toilet use. The resident always experienced

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urinary incontinence and staff placed the resident on a toileting program. The resident had one fall without injury since the prior assessment.

Resident #29's 8/27/13 Falls CAA (Care Area Assessment) summary reported the resident had a high risk for falls due to history of falls and difficulty picking up his/her left foot weakened by a stroke.

Resident #29's care plan, last reviewed on 8/28/13, informed staff that the resident posed a high risk for falls due to a past stroke. The care plan instructed staff to provide one to two person assistance as needed but did not specify what cares. The care plan instructed staff to keep his/her call light within reach at all times in his/her room. Interventions included staff to remind the resident to use a walker as the resident tended to forget to use it at times and that he/she used a wheelchair at times to propel him/herself throughout the facility. The care plan mentioned that the resident fell on 1/10/13, 6/3/13, 9/2/13, and 9/5/13, but lacked implementation of new interventions to prevent future falls.

During an observation on 10/16/13 at 12:30 p.m., resident #29 propelled him/herself with a wheelchair from the dining room to his/her room. At 12:31 p.m., resident #29 removed his/her own shoes while sitting in a wheelchair and transferred him/herself to bed while wearing non-slip socks. The resident's bed had a pad alarm that did not activate or engage when the resident laid on it.

During an interview on 10/21/13 at 1:40 p.m., Licensed Nursing Staff H reported that charge nurses did not revise resident care plans after

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falls but relied on the administrative staff.

During an interview on 10/21/13 at 2:35 p.m., Administrative Nursing Staff A reported that the facility expected charge nurses to update the care plan with interventions to prevent further falls after each fall.

The facility's 12/10/07"Falls and Fall Prevention" policy instructed staff that after a resident falls to review and update the resident's care plan.

The facility failed to review/revise resident #29's comprehensive care plan after the resident fell on 1/10/13, 6/3/13, 9/2/13, and 9/5/13 to prevent further falls.

- Resident #28's Physician Order Sheet dated 8/28/13 included diagnoses of Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and dementia (progressive mental disorder characterized by failing memory, confusion).

Resident #28's 7/8/13 Quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 7, which indicated severe cognitive impairment. The resident required limited assistance of 1 person for bed mobility. He/She required supervision for transfers, walking in his/her room, and toilet use. The resident's balance was not steady, but he/she had the ability to stabilize without assistance. The assessment indicated the resident had functional limitations in range of

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motion on one side of the upper extremities and used a walker and wheelchair for mobility. The resident had frequent urinary incontinence and occasional bowel incontinence. According to the assessment, the resident had 1 fall with minor injury and 1 fall with major injury since the prior assessment.

Resident #28's 11/10/12 Falls CAA (Care Area Assessment) summary reported a Fall Risk Assessment completed on 10/22/12 with a score of 15 (a score above 10 indicating a high risk for falls).

Resident # 28's Fall Risk Assessment on 10/15/13 revealed a score of 19 which indicated a high risk for falls.

Resident #28's 11/7/12 initial nursing care plan identified the resident as at risk for falls and directed staff to take the resident to the bathroom whenever the resident asked to go to the bathroom, before and after meals and activities, before going to bed and upon rising, and any time during the night. The care plan instructed staff that the resident needed a bed alarm and a chair alarm to alert staff and the resident that the resident was not to be up on his/her own. The care plan instructed the staff that resident # 28 required one staff assistance, a gait belt, and a walker when ambulating to and from meals, activities, and the bathroom at all times. The care plan instructed staff to encourage the resident to look up when walking, not to cross his/her feet when walking, and continue with low bed and mat on floor. The revised 7/17/13 nursing care plan included a list of falls on 10/19/12, 11/22/12, 1/26/13, 4/14/13, and 7/1/13, but lacked initiation of fall prevention strategies to prevent future falls.

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Review of the "Fall Post Incident and Procedure Guide" forms for falls sustained on 10/19/12, 11/22/12, 1/26/13, 4/14/13, 7/1/13, and 9/14/13, revealed resident #28 had multiple falls. The nursing care plan lacked evidence fall prevention strategies were initiated after each of these falls.

During an observation on 10/16/13 at 11:50 AM, resident #28 walked independently to the dining room with a walker and sat in a dining room chair with no alarms used.

During an observation on 10/16/13 at 2:55 PM resident # 28 stood up without staff assistance and used his/her walker to walk to the door of his/her room. The resident put a sweater on and ambulated to the dining room unassisted to play bingo. No alarms sounded.

During an interview on 10/21/13 at 2:38 PM, Licensed Nursing Staff H reported the care plans should be updated when needing a new intervention. Licensed Nursing Staff H reported the nurses did not add interventions to the care plans and only the MDS Coordinator revised the care plans.

During an interview on 10/21/13 at 3:50 p.m., administrative nurse A stated that following falls, the care plans should be revised and interventions placed to prevent future falls. Nurse A further stated the completed post fall assessment forms were evaluated by him/herself and the risk manager. He/she stated the charge nurse or MDS Coordinator should update the care plan after a fall.

The facility's 12/10/07 "Fall and Fall Prevention"

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F 280	Continued From page 13 policy and procedure stated, following each fall interventions determined to be needed are to be put in place as soon as possible to protect the resident. The policy also stated the plan of care should be reviewed to identify that interventions are documented. Falls were to be reviewed for possible alternative safety measures by the Risk Management Nurse, DON (Director of Nursing), or On-call Nurse. A review of the incident was to be completed by DON and Risk Manager, followed by review and revision of the care plan. The facility failed to revise and update resident #28's nursing care plan after the resident sustained multiple falls in order to prevent future falls.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to provide the necessary care and services (pain management) to attain or maintain the highest practical physical, mental, and psychosocial well-being for 1 of 2 residents	F 309		

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sampled with pain issues. (Resident #16)

Findings included:

- Resident #16's quarterly MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition. The resident required limited assistance of 1 person for transfers, walking in the room, dressing, and toilet use with supervision for personal hygiene. According to the assessment, the resident had almost constant pain that interfered with ADLs (activities of daily living). The resident received as needed pain medication and rated the pain as 10 (severe) on a scale of 0-10.

The Cognitive Loss CAA (care area assessment), dated 1/10/13, identified that the resident scored a BIMS of 12 indicating moderately impaired cognition. The CAA reported the resident complained of pain in his/her hips and low back. The resident requested Percocet (narcotic prescribed pain medication) and stated the resident will ask for the medication again 30 minutes after he/she received it.

The care plan included a risk for pain, dated 1/16/13, and identified the resident had a recent left hip repair and history of a status post right hip repair with a stated goal of: the resident will receive adequate pain relief for optimal comfort to participate in ADLs, directing staff to offer a change of position to help the resident discomfort. An entry for the self-care deficit problem dated 7/10/13 indicated the resident required an increase in assistance due to increased weakness and confusion, related to a medication change. The alteration in mobility

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problem sited a decrease in mobility. A risk for pain entry on 7/10/13 directed the resident to walk 4 times a day to and from the bathroom per physician orders. A risk for pain entry on the care plan on 10/3/13 stated the resident only walks to and from the bathroom and did not want to walk further.

The resident's physician orders included the following to treat pain:
* Neurontin 100 mg (milligrams) orally twice a day for pain
* Acetaminophen 325 mg orally with Percocet as needed, both medications combined not to exceed 3000 mg in 24 hours
* Percocet 5/325 mg orally every 4 to 6 hours as needed for pain not to exceed 3000 mg Acetaminophen
* Bio freeze as needed to affected areas

The physician progress note dated 8/28/13 stated the resident was examined for complaints of pain and always hurt. Interventions included increasing the Neurontin and a Fentanyl Patch but caused increased confusion and dizziness. The progress note dated 7/3/13 gave the diagnoses of Degenerative Joint Disease (a condition of chronic arthritis without inflammation which affects the joints), Osteoarthritis (a condition of chronic arthritis without inflammation), Chronic Pain (pain persisting for a long period, often for the remainder of a person's lifetime), Neuropathy (damage involving nerves of the peripheral nervous system, which may affect sensation and movement), and noted Depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) had improved.

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The Medication Administration Record included daily complaints of pain by the resident. The Percocet and Acetaminophen were administered as listed on the following dates in October 2013 - given 1 time on 13 and 18; given 2 times on 2, 3, 4, 10, 14, 17, 21; given 3 times on 1, 6, 7, 8, 9, 10, 11, 12, 15, 16; given 4 times on 5, and 19. Biofreeze was administered on 10/4/13 and 10/16/13. Staff failed to obtain follow-up results for effectiveness after administering the pain medication to the resident on the following dates: 10/2/13 twice, 10/7/13 twice, 10/10/13 once, 10/12/13 once, 10/14/13 once, 10/15/13 once, 10/16/13 once, 10/17/13 twice, 10/19/13 once, and 10/20/13 twice. The Percocet and Acetaminophen order stated to administer every 4-6 hours as needed for pain. The medication order made the medication available for administration up to 6 times per day for complaints of pain.

During an observation on 10/16/17 at 09:45 a.m. direct care staff I assisted the resident to transfer and ambulate to and from the bathroom, with use of a gait belt and a FWW (front wheeled walker). The resident verbalized complaints of pain to his/her hips and knees, multiple times. Staff I informed the resident he/she would notify the nurse of the complaint.

During an observation on 10/16/13 at 3:50 p.m. direct care staff P assisted the resident to transfer and ambulate to the bathroom, with use of a gait belt and FWW, as the resident ambulated, he/she made soft moaning noises and expressed facial grimaces. The resident verbalized to staff P that his/her hips hurt.

During an observation on 10/16/13 at 4:20 p.m.

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direct care staff P and licensed nursing staff R stood in the resident room doorway. The nurse attempted to explain the benefit of the resident pushing his/her own wheelchair to the dining room. The resident was anxious and upset, he/she verbalized in a raised tone of voice "It hurts, you don't have any idea." The resident repeated multiple times that he/she had pain and could not push him/herself in the wheelchair and asked if she could have a ride.

During an interview on 10/22/13 at 10:55 a.m., physician O stated resident # 16 verbalized the presence of pain and stated he/she "always hurt, always had aches". Physician O further stated the resident had a diagnosis of depression, but could be redirected from thoughts of pain during a conversation or visit. According to the physician the resident dosage of Zoloft (an anti-depressant) was increased. The physician also stated an attempt to increase the resident's Neurontin was unsuccessful due to side effects of sleeping during the day, so the dose was decreased.

During an interview on 10/16/13 at 9:45 a.m., direct care staff I reported this resident frequently voiced complaints of pain to hip and staff I reported the resident complaints of pain to the Charge Nurse.

During an interview on 10/17/13 at 3:00 p.m., Licensed Nursing Staff R stated the resident frequently made complaints of pain. As the Charge Nurse he/she administered narcotic pain medication and other medicated products like Biofreeze. The Charge Nurse provided education to the resident on the time constraints between medication doses. Staff S reported the resident had behaviors and would cry out when it was too

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F 309	Continued From page 18 soon for another dose of pain medication. Staff S stated as the charge nurse she can apply the Biofreeze gel to the resident hip area for complaints of pain. The facility's 5/14/12 Administration of Medication policy stated "PRN (as needed) medications are charted with initials and time on the MAR (medication administration record). In addition, record the date, time, medication given, route, dose, nurse's initials, reason and effect of PRN on the PRN part of the MAR." The facility failed to administer medication to the resident when he/she voiced complaints of pain, although the medication was available as ordered by the physician. The facility failed to monitor the effectiveness of the pain medication after being administered.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents with 12 residents sampled for review. The facility reported 19 of the 39 residents as independently mobile with cognitive impairment. The sample included 4 residents reviewed for accidents.	F 323		

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Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents/falls for 2 of 3 residents sampled for accidents related to falls. (#29 and #28) Resident #28 fell on 11/22/12 and sustained an injury which required sutures. Resident #28 sustained another fall on 7/1/13 which required surgical repair of a fractured thumb.

Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free from potential accidents with the use of bed rails with large gaps that posed a potential for entrapment for 1 sampled residents. (#4)

Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accidents/hazards for 19 independently mobile cognitively impaired residents when staff stored potentially hazardous chemicals in areas accessible to residents.

Findings included:

- Resident #28's Physician Order Sheet dated 8/28/13 included diagnoses of Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and weakness) and dementia (progressive mental disorder characterized by failing memory, confusion).

Resident #28's 7/8/13 Quarterly MDS (minimum

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data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 7, which indicated severe cognitive impairment. The resident required limited assistance of 1 person for bed mobility. He/She required supervision for transfers, walking in his/her room, and toilet use. The resident's balance was not steady, but he/she had the ability to stabilize without assistance. The assessment indicated the resident had functional limitations in range of motion on one side of the upper extremities and used a walker and wheelchair for mobility. The resident had frequent urinary incontinence and occasional bowel incontinence. According to the assessment, the resident had 1 fall with minor injury and 1 fall with major injury since the prior assessment.
Resident # 28's 11/10/12 Falls CAA (Care Area Assessment) summary reported a Fall Risk Assessment completed on 10/22/12 with a score of 15 (a score above 10 indicating a high risk for falls).

Resident # 28's Fall Risk Assessment on 10/15/13 revealed a score of 19 which indicated a high risk for falls.

Resident #28's 11/7/12 initial nursing care plan identified the resident at risk for falls and directed staff to take the resident to the bathroom whenever the resident asked to go to the bathroom, before and after meals and activities, before going to bed and upon rising, and any time during the night. The care plan instructed staff that the resident needed a bed alarm and a chair alarm to alert staff and resident that the resident was not to be up on his/her own. The care plan instructed the staff that resident # 28 required one staff assistance, a gait belt, and a walker when

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ambulating to and from meals, activities, and the bathroom at all times. The care plan instructed staff to encourage the resident to look up when walking, not to cross his/her feet when walking, and continue with low bed and mat on floor. The revised 7/17/13 nursing care plan included a list of falls on 10/19/12, 11/22/12, 1/26/13, 4/14/13, and 7/1/13, but lacked initiation of fall prevention strategies to prevent future falls.

Resident #28's "Fall Post Incident and Procedure Guide" dated 10/19/12 revealed the resident fell while going to the bathroom independently. The initial care plan dated 11/7/12 included fall prevention interventions.

A "Fall Post Incident and Procedure Guide" dated 11/22/12 revealed resident #28 fell in the bathroom while flushing the toilet. According to the form, no alarms were sounding. The resident sustained a laceration of the lip that required stitches in the emergency room. The form included interventions to "encourage to use the call light" and instructed the resident to not flush the toilet. (The nursing care plan did not include these interventions to prevent future falls.)

A "Fall Post Incident and Procedure Guide" on 1/26/13 revealed resident #28 fell in the bathroom while flushing the toilet. The nursing care plan listed the fall on 1/26/13, but lacked initiation of any fall prevention strategies to prevent future falls.

Resident #28's 4/14/13 "Fall Post Incident and Procedure Guide" stated the resident fell while ambulating to the bathroom and fell when another resident handed him/her a paper. The form included an intervention to encourage the

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resident to use his/her walker. (The nursing care plan did not include the intervention listed on the form).

Resident #28's 7/1/13 "Fall Post Incident and Procedure Guide" revealed the resident fell while trying to change an incontinence brief. According to the form, the bathroom was occupied and the resident attempted to change the brief independently. He/she had both legs in one hole of the brief. The form indicated the alarms did not sound. The resident sustained a dislocated left thumb that required surgical intervention for repair. (The care plan lacked fall prevention strategies to prevent future falls)

A "Fall Post Incident and Procedure Guide" dated 9/14/13 stated resident #28 fell in the bathroom. (The care plan lacked fall prevention strategies to prevent falls).

Review of the "Fall Post Incident and Procedure Guide" forms for falls on 10/19/12, 11/22/12, 1/26/13, 4/14/13, 7/1/13, and 9/14/13 lacked evidence that the facility evaluated each fall for causative factors and placed fall prevention strategies to prevent future falls.

During an observation on 10/16/13 at 11:50 AM, resident #28 walked independently to the dining room with a walker and sat in a dining room chair with no alarms used.

During an observation on 10/16/13 at 2:55 PM resident # 28 stood up without staff assistance and used his/her walker to walk to the door of his/her room. The resident put a sweater on and ambulated to the dining room unassisted to play bingo. No alarms sounded.

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During an interview on 10/17/13 at 2:05 PM, Direct Care Staff G reported resident #28 had alarms on his/her bed and his/her recliner. The resident stands up, the alarm goes off and the resident pushed the button to turn the alarm off. Staff G further stated the resident turned the alarms off by the time staff responded to them. During an interview on 10/21/13 at 2:38 PM, Licensed Nursing Staff H reported the care plans should be updated whenever an intervention is needed. Licensed Nursing Staff H reported the nurses do not add interventions to the care plans, only the MDS Coordinator revises the care plans.

During an interview on 10/21/13 at 3:50 p.m., administrative nurse A stated that following falls, the care plans should be revised and interventions placed to prevent future falls. Nurse A further stated the completed post fall assessment forms were evaluated by him/herself and the risk manager. He/she stated the charge nurse or MDS Coordinator should update the care plan after a fall. Nurse A confirmed that resident #28 knew how to reset the alarm, but could not turn it off.

Attempts to call physician W on 10/23/13 at 9:28 a.m. revealed the physician was unavailable for interview.

The facility's 12/10/07 "Fall and Fall Prevention" policy and procedure stated, following each fall interventions determined to be needed are to be put in place as soon as possible to protect the resident. The policy also stated the plan of care should be reviewed to identify that interventions are documented. Falls were to be reviewed for possible alternative safety measures by the Risk

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Management Nurse, DON (Director of Nursing), or On-call Nurse. A review of the incident was to be completed by DON and Risk Manager, followed by review and revision of the care plan.

The facility failed to ensure resident #28 received adequate supervision and assistive devices to prevent accidents. Resident #28 sustained a fall on 11/22/12 which required sutures in the emergency room and a fall on 7/1/13 which required surgical repair of a fractured thumb. The facility failed to evaluate each fall for causative factors and implement fall prevention strategies to prevent future falls for this cognitively impaired resident.

- Resident # 4's annual MDS 3.0 (Minimum Data Set) dated 8/13/13 identified the resident had a BIMS (brief interview for mental status) score of 8, total dependence on 1 staff person required for bed mobility, transfer, locomotion, toilet use and extensive assist of 1 staff person for dressing and personal hygiene. Staff assistance required to stabilize resident for surface to surface transfer. Upper extremities had impairment on one side, lower extremities had impairment on both sides, and the resident used a W/C (wheelchair) and bed rails.

The 8/25/13 cognitive loss/delirium CAA (Care Area Assessment) revealed a BIMS of 8, decreased from 11. The falls CAA documented the resident as a high risk for falls due to a diagnosis of Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, forward flexion of the trunk, loss of postural reflexes and muscle rigidity and

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weakness) and limited mobility. According to the summary, staff transferred the resident with a full body lift and used a wheelchair for mobility.

Resident #4's 8/21/13 nursing care plan revealed the resident had a self-care deficit requiring moderate to maximum assistance for mobility. Alteration in cognition revealed poor decision making ability and at risk for falls due to a diagnosis of CVA (cerebrovascular accident/stroke is the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain) with hemiplegia (paralysis of one side of the body) on the left side.

The resident physician's orders did not provide an order for side rail use.

During an observation on 10/14/13 at 9:50 a.m., direct care staff I and L physically moved the resident up in the bed with a turn pad. Staff elevated the head of the resident's bed to approximately 80 degree which enabled the resident to eat a snack. Staff lowered the side rail on the bottom half of the bed. The bed rail extended to cover 3/4 the length of the bed, the rail split in half horizontally, and was divided into 6 gaps. The gaps on each end of the rail (4 gaps), top and bottom measured 10 inches in length by 5 5/8 inches in height, the gaps in the middle measured 30 inches in length by 5 5/8 inches in height.

During an interview on 10/16/13 at 3:16 p.m., staff I stated the resident had minimal movement of his/her lower body, but did move his/her upper arm freely. Staff I was not familiar with bed rail safety entrapment risk.

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During an interview on 10/17/13 at 3:00 p.m., licensed nursing staff R stated resident #4 had limited mobility with stiff and painful lower extremities. The resident had use of 1 upper extremity. Staff was not familiar with bed rail safety entrapment risk.

During an interview on 10/15/13 at 4:20 p.m., administrative nursing staff A was not aware the side rails on resident #4's bed did not meet the bed safety entrapment guidelines for the side rail or the gap between the mattress and the rails.

The Center for Devices and Radiological Health Guidance dated 3/2006 revealed that the Food Drug Administration recommended that the greatest side rail gap to prevent head entrapment was 4.75 inches.

Although requested the facility failed to provide a policy and procedure addressing bed and side rail entrapment risks.

The facility failed to protect resident #4 from entrapment risk with the use of side rails with gaps greater than 4 ¾ inches.

- Resident #29's 9/9/13 signed physician's orders included diagnoses of arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), and history of a stroke (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain).

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Resident #29's 8/20/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident usually understood others, usually made him/herself understood, and had moderately impaired cognition. The resident independently moved in bed and throughout the facility with a walker or a wheelchair and needed limited assistance of one staff for transfers and toilet use. The resident always experienced urinary incontinence and staff placed the resident on a toileting program. The resident had one fall without injury since the prior assessment.

Resident #29's 8/27/13 Falls CAA (Care Area Assessment) summary reported the resident had a high risk for falls due to history of falls and difficulty picking up his/her left foot weakened by a stroke.

Resident #29's "Fall Risk Assessment" revealed that staff scored the resident as "16" on 6/16/13, "20" on 8/14/13, "20" on 9/2/13, "16" on 9/5/13, and "18" on 9/12/13. The assessment indicated that residents with scores greater than 10 posed a high risk for falls.

Resident #29's care plan, last reviewed on 8/28/13, informed staff that the resident posed a high risk for falls due to a past stroke. The care plan instructed staff to provide one to two person assistance as needed but did not specify what cares. The care plan instructed staff to keep his/her call light within reach at all times in his/her room. Interventions included staff to remind the resident to use a walker as the resident tended to forget to use it at times and that he/she used a wheelchair at times to propel him/herself throughout the facility. The care plan mentioned that the resident fell on 1/10/13, 6/3/13, 9/2/13,

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and 9/5/13 but lacked implementation of a new interventions to prevent further falls. After a fall on 9/12/13, staff revised the care plan on 9/13/13 to assist the resident with his/her ADLs (activities of daily living). On 10/7/13, staff revised the care plan to place an alarm on his/her bed and "chair" and to help the resident with grooming as needed.

Review of the resident's faxed communication to the physician revealed that the resident fell on 12/30/12 that reported that staff found the resident on the floor of his/her room without pants on at 12:55 p.m. Nursing staff documented they found a scratch on his/her back but no other injuries. A "Post Fall Assessment" form reported that nursing staff assessed the resident for injuries, reported the resident's vital signs as normal, and notified the resident's physician and family of the incident. Although the resident fell on 12/30/12, the care plan lacked mention of this fall and lacked a revision with an intervention to prevent future falls.

Review of the resident's faxed communication forms revealed that staff found the resident on the floor outside his/her bathroom on 1/10/13 at 4:40 p.m. A "Post Fall" Assessment" on 1/10/13 documented the resident had no injuries, reported his/her vital signs as normal, and staff notified the resident's physician and family of the incident.

Review of the resident's "Post Fall Assessment" forms revealed that staff witnessed that resident #29 fell on 6/4/13 at 8:40 p.m. while ambulating in his/her room without his/her walker. Documentation included that he/she reached for the bathroom door handle, missed it, and landed on his/her bottom. Nursing staff assessed the

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resident, found no injuries, and notified the resident's physician and family of the incident.

Review of the resident's "Post Fall Assessment" forms revealed that resident #29 slid out of bed on 9/3/13 at 5:10 a.m. Nursing staff documented the resident had no injuries or abnormal vital signs and notified the resident's physician and family of the incident.

Review of resident #29's 9/5/13 "Post Fall Assessment" forms revealed that staff found the resident sitting upright on the floor in the middle of his/her room. The resident reported he/she walked to his/her recliner from his/her closet after selecting clothing without a walker and he/she slipped and fell. Nursing staff documented the resident had no injuries or abnormal vital signs and reported the incident to the resident's physician and family.

A "Post Fall Assessment" form on 9/12/13 revealed that resident #29 fell at 7:00 p.m. as staff documented that the resident did not wear non-slip footwear while attempting to get out of bed without assistance and had no injuries. Nursing staff indicated on the form to "make sure has non-slip footwear on" and notified the resident's physician and family about incident.

During an observation on 10/16/13 at 12:30 p.m., resident #29 propelled him/herself with a wheelchair from the dining room to his/her room. The wheelchair had no alarms. At 12:31 p.m., resident #29 removed his/her own shoes while sitting in a wheelchair and transferred him/herself to bed while wearing non-slip socks. The resident's bed had a pad alarm that did not activate or engage when the resident laid on it.

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At 1:49 p.m., Direct Care Staff M came into resident #29's room and placed a blanket over him/her but failed to check the resident's bed alarm to ensure it was functioning. At 2:31 p.m., the resident sat on the side of the bed, placed his/her own shoes on, and transferred him/herself to the wheelchair without calling for assistance.

During an interview on 10/16/13 at 12:40 p.m., Direct Care Staff L reported that resident #29 liked to be an independent as possible though he/she was weak and needed to wait for assistance as he/she fell often while attempting to do ADLs without help. Staff L stated that interventions to keep him/her from falling included making sure he/she had on non-slip socks and to turn a bed alarm on manually when he/she goes to bed or sits in a recliner. Staff L reported that staff did not use an alarm on the resident's wheelchair.

During an interview on 10/17/13 at 4:09 p.m., Direct Care Staff J reported that resident #29 posed as a high risk for falls as he/she fell often while attempting to do ADLs without assistance. Staff J reported that staff check on the resident frequently, remind him/her to use the call light, and turn on an alarm on the bed or recliner. Staff J reported a lack of awareness if staff placed an alarm on the resident while he/she sat in a wheelchair.

During an interview on 10/21/13 at 1:40 p.m., Licensed Nursing Staff H reported that charge nurses did not revise resident care plans after falls but relied on the administrative staff. Staff H reported that nursing staff placed an alarm on his/her bed and recliner as the resident repeatedly attempted to care for him/herself

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without assistance and refused to use a call light to ask for help. Staff H reported he/she did not know why staff did not use an alarm on his/her wheelchair and agreed the resident should have assistance when transferring.

During an interview on 10/21/13 at 2:35 p.m., Administrative Nursing Staff A reported that an intervention for alarms in chair meant any chair that resident #29 sat on, whether that was a wheelchair or a recliner. Staff A reported that the facility expected charge nurses to update the care plan with interventions to prevent further falls after each fall.

The facility's 12/10/07"Falls and Fall Prevention" policy instructed staff that after a resident falls to review and update the resident's care plan.

The facility failed to ensure that resident #28, who fell multiple times between December 2012 and September 2013, received adequate supervision to prevent accidents when staff failed to revise and implement new interventions to prevent further falls or ensure the resident had an alarm in his/her wheelchair as instructed in his/her comprehensive care plan.

- An observation during an initial tour on 10/14/13 at 11:03 a.m. revealed an unlocked soiled utility room on the west hall with the following chemicals accessible to residents:
* Johnson Wax Professional General Purpose Cleaner with 650 ml (milliliters) labeled "Keep out of reach of children, Caution: Avoid contact with skin and eyes. Flush immediately if contact occurs."
* Johnson Wax Professional One Step Germicide Cleaner and Deodorant 625 ml,

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F 323	Continued From page 32 labeled "Avoid contact with eyes and skin, flush immediately if such contact occurs. If irritation develops, seek medical attention." * Butcher's Breakdown XC Odor Eliminator, 1000 ml bottle labeled "Avoid contact with eyes and skin, wear suitable protective clothing." * Unlabeled bottle of pink solution 1000 ml. During an interview on 10/14/13 at 11:23 a.m., administrative nurse A stated the soiled utility room door locked automatically when the door shut and further stated the bottle with the pink solution should be labeled with the contents. At 11:36 a.m., administrative nurse A returned to the soiled utility room and the door opened. Nurse A stated, "that didn't lock after I left." The facility's 5/14/12 Safety Regulations policy stated, "Hazardous substances are not left unattended at any time or stored in areas accessible to residents." The facility failed to ensure the resident environment remained free of accidents/hazards by storing potentially hazardous chemicals in areas accessible to 19 cognitively impaired, independently mobile residents.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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nutritional problem.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 39 residents with 12 residents sampled for review and 3 residents sampled for weight loss.

Based on observation, interview, and record review, the facility failed to ensure that 1 of the 3 residents maintained acceptable parameters of nutritional status such as body weight when staff failed to follow recommendations from the consulting registered dietician. (Resident #29)

Findings included:

- Resident #29's 9/9/13 signed physician's orders included diagnoses of CHF (congestive heart failure or a condition when the heart output is low and the body becomes congested with fluid), diabetes mellitus type II (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), Gastro-esophageal reflux (backflow of stomach contents to the esophagus), and stroke (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain).

Resident #29's 8/20/13 Significant Change of Status MDS (Minimum Data Set) reported the resident usually understood others, usually made him/herself understood, and had moderately impaired cognition. The MDS reported the resident had no natural teeth. The resident ate

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independently, received a therapeutic diet, and experienced weight loss greater than 5% in one month or 10% in 6 months during the observation period. The resident received diuretics 7 of the 7 day observation period.

Resident #29's 8/27/13 Nutritional CAA (Care Area Assessment) summary reported that his/her current weight decreased 21 pounds in the last 90 days, he/she transferred recently to an acute hospital for nausea/vomiting which contributed to his/her weight loss, and continued to receive a low concentrated sweets diet. The summary also reported that the resident had increasing edema (swelling) to the legs due to CHF.

Resident #29's 3/6/13 care plan informed staff that the resident ate independently, had adjusted to new dentures, and at times did not wear the dentures due to discomfort. The care plan instructed staff to encourage the resident to drink fluids as he/she had the potential for dehydration due to medications he/she received for his/her diagnosis of CHF. On 8/28/13, staff revised the care plan that the resident ate less due to abdominal pain. On 9/23/13, staff revised the care plan to encourage the resident to not eat popcorn to limit the amount of abdominal pain.

Review of the resident's physician's orders included a 3/6/12 order for a low concentrated sweets diet and to offer a snack three times a day. The resident received Lasix (a diuretic) 40 mg (milligrams) orally daily with a start date of 12/28/12 for CHF. On 8/14/13, the physician ordered to add an additional 20mg of Lasix daily.

Review of the resident's weight record revealed that the resident weighed 202 pounds on 7/2/13.

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On 9/3/13, the resident weighed 177 pounds, a drop of 25 pounds (a loss of 12.37% in 64 days).

Review of resident #29's physician's progress notes on 9/9/13 reported the resident complained of abdominal pain and nausea, had episodes of vomiting, and that he/she lost weight. The physician noted the resident weighed 177 pounds and diagnosed the resident with diverticulitis (inflammation of the diverticulum, in the colon, which causes pain and disturbance in bowel function). The physician treated the new condition of diverticulitis with medication. On 9/18/13 the physician documented that the resident recently had an acute hospital stay for acute CHF and an urinary tract infection (an infection that affects the bladder) that caused the resident to have nausea, vomiting, and stop eating which also contributed to the resident's weight loss.

Review of resident #29's dietary notes revealed on 9/10/13, the consulting registered dietician documented that the resident lost 25 pounds in approximately 60 days, had poor food intake due to feeling ill and a recent hospital stay due to nausea and vomiting. The consulting registered dietician recommended to offer the resident a sugar-free nutritional supplement if the resident did not eat a meal. Review of the clinical record lacked evidence that staff followed the recommendations.

Review of the resident's weight record revealed that the resident weighed 172 pounds on 10/1/13, a drop of 30 pounds since 7/2/13 (a loss of 18.6% in 93 days).

Review of resident #29's dietary notes revealed

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on 10/8/13, the consulting registered dietician documented that the resident lost another 5 pounds, adjusted the calculations of the residents caloric needs to increase healing, and recommended to give the resident a nutritional supplement at 3:00 p.m. and at night. Review of the clinical record lacked evidence that staff followed the recommendations.

During an observation on 10/16/13 at 11:46 a.m., resident #29 received a regular portion of beef stroganoff, a serving of steamed broccoli and cauliflower, a roll with butter, and a smaller serving of pumpkin bread with whipped cream. The resident ate independently without difficulty chewing. At 12:12 p.m., the resident ate 100% of the meal provided and declined to eat more when offered another serving by Direct Care Staff U.

During an interview on 10/21/13 at 8:21 a.m., Dietary Staff F reported he/she met with the consulting registered dietician monthly and informed the dietician of all residents with weight loss issues, including resident #29. Staff F reported he/she knew that the registered dietician made recommendation for multiple residents on 9/10/13 and 10/8/13 and he/she brought such recommendations to the awareness of other department members such as Administrative Nursing Staff A, but could not recall why staff did not follow up on the recommendations on either date.

During an interview on 10/21/13 at 2:35 p.m., Administrative Nursing Staff A reported a lack of awareness that the registered dietician made recommendations on 9/10/13 or 10/8/13 for resident #29.

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F 325	Continued From page 37 The facility failed to ensure resident #29 received nutritional supplements as recommended by consulting registered dietician on 9/10/13 and 10/8/13.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents with 5 residents reviewed for unnecessary medications.	F 329		

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Based on observation, record review, and interview the facility failed to ensure 3 of 5 residents sampled did not receive unnecessary drugs when the facility failed to monitor for effectiveness of medications for resident #8, #16, and #38.

Findings included:

- Resident # 16 quarterly MDS 3.0 (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition. According to the assessment, the resident had almost constant pain that interfered with ADLs (activities of daily living). The resident received as needed pain medication and rated the pain as 10 on a scale of 0-10.

The Cognitive Loss CAA (care area assessment) dated 1/10/13 identified that the resident scored a BIMS of 12 indicating moderately impaired cognition. The CAA reported the resident complained of pain in his/her hips and low back. The resident requested Percocet (narcotic prescribed pain medication) and stated the resident will ask for the medication again 30 minutes after he/she received it.

Resident # 16's care plan included a risk for pain problem dated 1/16/13 that identified the resident had a recent left hip repair and history of a status post right hip repair with a stated goal of: The resident will receive adequate pain relief for optimal comfort to participate in ADLs, directing staff to offer a change of position to help the resident discomfort.

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The resident's physician orders included the following PRN (as needed) medications to treat pain:
* Acetaminophen 325 mg orally with Percocet as needed, both medications combined not to exceed 3000 mg in 24 hours
* Percocet 5/325 mg orally every 4 to 6 hours as needed for pain not to exceed 3000mg Acetaminophen
* Bio freeze as needed to affected areas

The Medication Administration Record revealed the staff failed to obtain follow-up results for effectiveness after administering the pain medication to the resident on the following dates: 10/2/13 twice, 10/7/13 twice, 10/10/13 once, 10/12/13 once, 10/14/13 once, 10/15/13 once, 10/16/13 once, 10/17/13 twice, 10/19/13 once, and 10/20/13 twice.

During an observation on 10/16/17 at 09:45 a.m. direct care staff I assisted the resident to and from the bathroom. The resident verbalized complaints of pain to his/her hips and knees, multiple times. Staff I informed the resident he/she would notify the nurse of the request for pain medication.

During an observation on 10/16/13 at 3:50 p.m. direct care staff P assisted the resident to and from the bathroom, he/she made soft moaning noises and expressed facial grimaces. The resident verbalized to staff P that his/her hips hurt. Staff P stated she would notify the charge nurse and verify if pain medication could be given,

During an interview on 10/17/13 at 3:00 p.m., Licensed Nursing Staff R stated the resident

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frequently made complaints of pain. As the Charge Nurse he/she administered narcotic pain medication and other medicated products like Biofreeze. After he/she administered a PRN medication, the nurse should follow up with the resident for effectiveness.

During an interview on 10/21/13 2:50 p.m. Administrative Nursing Staff A stated the nursing staff that administered as needed medications were expected to follow-up on the effectiveness of the medication within 2 hours.

The facility's 5/14/12 Administration of Medication policy stated "PRN (as needed) medications are charted with initials and time on the MAR (medication administration record). In addition, record the date, time, medication given, route, dose, nurse's initials, reason and effect of PRN on the PRN part of the MAR."

The facility failed to monitor the effectiveness of the pain medication after being administered for resident # 16.

- Resident #8's 9/25/13 physician's orders included a diagnosis of Multiple Sclerosis (progressive disease of the nerve fibers of the brain and spinal cord).

Resident #8's 8/16/13 Annual MDS (Minimum Data Set) Assessment reported that the resident understood others, made him/herself understood, and had no cognitive impairment. The MDS reported he/she had moderate depression and no behaviors. The resident experienced pain that he/she rated as a 6 out of 10 that affected his/her sleep and daily activities.

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Resident #8's Mood, Psychotropic Drug Use, and Pain CAA (Care Area Assessment) summaries reported the resident felt that he/she had little energy and trouble sleeping and saw a licensed social worker on a regular basis. The resident complained of occasional headaches during the observation period. The resident received multiple medications for pain, including Robaxin for muscle spasms and Gabapentin for nerve pain on a regular basis and Tylenol and Ultram as needed.

Resident #8's 8/28/13 care plan informed staff that the resident experienced pain due to multiple back surgeries, had right hip pain, and experienced pain from the diagnosis of Multiple Sclerosis. Interventions included having the resident rate his/her pain from 0 as none to 10 as the worst, give pain medications as ordered, and monitor the response and effectiveness of the pain medications.

Review of the resident's physician's orders included orders for as needed pain medication:
* Norco 5/325 mg (milligrams) 1 tablet orally every 6 hours as needed for pain with a start date of 9/25/13
* Ultram 50 mg orally every 6 hours as needed for pain, give one tablet for pain rated between 1 - 5 and 2 tablets for pain rated between 6 and 10 with a start date of 8/28/12
* Tylenol 325 mg orally every 4 to 6 hours as needed, give one tablet for pain rated between 1 - 5 and 2 tablets for pain rated between 6 - 10

Review of the resident's September 2013 MAR (Medication Administration Record) revealed that staff documented as needed medication on the

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back of the sheet with a space to document how effective the medication treated the issue. Staff documented that the resident received Tylenol 325 mg 2 tablets 62 times and staff failed to monitor the effectiveness of Tylenol 22 of the 62 times. The resident received Norco 2 tablets 13 times and staff failed to monitor the effectiveness 1 of the 13 times.

Review of the resident's October 2013 MAR revealed staff gave the resident Norco 2 tablets 49 times and staff failed to monitor the effectiveness of Norco 14 of the 49 times. The resident received Tylenol 4 times and staff failed to monitor for the effectiveness 2 of the 4 times.

During an observation on 10/15/13 at 4:31 p.m., resident #8 walked independently in the hallway while he/she used a walker, took slow, determined steps, and stopped after a few steps taking deep breaths.

During an interview on 10/21/13 at 1:40 p.m., Licensed Nursing Staff H reported that the facility expected nursing staff to check on a resident, such as resident #8, approximately an hour or two after staff gave the pain medication to see if the medication controlled his/her pain. Staff H reported nursing staff should write the result of the pain medication on the back of the MAR sheets in the space provided. Staff H verified that staff failed to check the results of pain medication for resident #8 throughout September and October 2013.

The facility failed to ensure that resident #8 did not receive unnecessary medications when staff failed to adequately monitor the resident's use of as needed pain medications during September

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and October of 2013.

- Resident #38's 8/28/13 physician's orders included diagnoses of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vascular dementia (progressive mental disorder characterized by failing memory, confusion) with delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and gout (inflammation of the joints).

Resident #38's 7/17/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident usually understood others, made him/herself understood, and had severely impaired cognition. The resident had fluctuating inattention, disorganized thinking, and altered levels of consciousness. The resident experienced mild depression and delusions. He/she displayed disruptive behavior not directed toward others 1 to 3 days of the 7 day observation period that interrupted activities and the living environment of others. The resident experienced no pain and received antipsychotic, antianxiety, and antidepressant medications for 7 of the 7 observation days.

Resident #38's 7/23/13 Psychotropic Drug Use CAA (Care Area Assessment) summary reported that the resident received Seroquel (an antipsychotic medication) for hallucinations and inappropriate behavior toward staff and Pristiq for depression.

Resident #38's care plan, last reviewed on 7/24/13, informed staff that the resident transferred to a geriatric psychiatric hospital on

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6/24/13 and returned to the facility on 7/11/13. The care plan informed staff that the resident was at risk for elopement and instructed staff to go on walks outside in good weather or invite the resident to watch football on television. The care plan indicated the resident experienced pain at time due to gout, give pain medications as needed and monitor the effectiveness of the medication, and that the resident will not always verbalize his/her pain so watch for facial expressions.

Review of the resident's physician's orders included orders for:
* Ativan 1 mg orally every 8 hours as needed for agitation with start date of 3/24/13
* Ativan 1 mg/ml topically as needed every 4 hours for agitation with a start date of 7/11/13
* Lortab (a pain medication) 5/500 1 tablet orally every 4 hours for pain with a start date of 8/7/13

Review of resident #38's September 2013 MAR (Medication Administration Record) revealed that staff documented as needed medications on the back of the sheet with space provided to monitor results. Staff gave the resident Ativan orally 26 times and failed to monitor the effectiveness of the medication 8 of the 26 times. Nursing staff documented that the resident received Lortab 8 times and failed to monitor the effectiveness 2 of the 8 times.

Review of the resident's October 2013 MAR revealed that staff gave the resident Ativan 16 times and failed to monitor the effectiveness 4 of the 16 times. Staff documented they gave the resident Lortab 16 times and failed to monitor the effectiveness 4 of the 16 times.

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F 329	Continued From page 45 During an observation on 10/15/13 at 2:41 p.m., resident #38 ambulated independently, spoke in a loud voice, and while putting on his/her coat he/she told Direct Care Staff V he/she was going to the library. Staff V invited the resident to walk with him/her outside and reported to other staff he/she and resident #38 were about to leave the facility to take a walk. After Staff V entered the code to exit the south facing/north hallway door, resident #38 pushed open the door and refused to move unless Staff V walked back into the building. Activity/Social Service Staff Q walked next to resident #38 and invited him/her to walk outside while Staff V entered the building. Resident #38's demeanor calmed as Staff Q walked with the resident outside. During an interview on 10/21/13 at 1:40 p.m., Licensed Nursing Staff H reported that the facility expected nursing staff to check on a resident, such as resident #38, approximately an hour or two after staff gave the medication to see if the medication worked. Staff H reported nursing staff should write the result of the medication on the back of the MAR sheets in the space provided. Staff H verified that staff failed to check the results of pain and anxiety medication for resident #38 throughout September and October 2013. The facility failed to ensure that resident #38 did not receive unnecessary medications when staff failed to adequately monitor the effectiveness of pain and antianxiety medication in September and October 2013.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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F 371	Continued From page 46 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The facility had one kitchen and one dining room. Based on observation, interview, and record review, the facility failed to serve food under sanitary conditions (use of contaminated gloves while assisting residents with eating). (Resident #4, non-sampled resident #13, and non-sampled resident #26) Findings included: - During an observation on 10/14/13 at 11:20 a.m. dietary staff T wore gloves and picked up a fork used by resident #4 after he/she attempted to self-feed. Dietary staff T then reached across the table and buttered resident #13's cornbread with the contaminated gloves. During an observation on 10/14/13 at 11:57 a.m. dietary staff U touched the back of a wheelchair handle, then buttered non-sampled resident #26's cornbread with the contaminated gloves. During an interview on 10/14/13 at 12:12 p.m., dietary staff F stated he/she expected dietary staff to remove gloves after helping a resident or	F 371		

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F 371	Continued From page 47 if the gloves were soiled. The facility's 9/23/12 Sanitary Food Service policy stated, "The Dietary Department will serve food in a sanitary manner in order to avoid contamination of food served to residents. " The policy further stated, " Change gloves and wash hands after hands have come in contact with anything that may contaminate the food." The facility failed to serve food under sanitary conditions.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 39 residents with 5 residents reviewed for unnecessary medication. Based on observation, record review, and interview the facility failed to ensure the consultant pharmacist reported irregularities to the attending physician and director of nursing, and these reports were acted upon related to	F 428		

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monitoring of effectiveness of as "needed" medications for 3 of 5 sampled residents. (#8, #16, and #38)

Findings included:

- Resident # 16 quarterly MDS 3.0 (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 9 which indicated moderately impaired cognition. According to the assessment, the resident had almost constant pain that interfered with ADLs (activities of daily living). The resident received as needed pain medication and rated the pain as 10 on a scale of 0-10.

The Cognitive Loss CAA (care area assessment) dated 1/10/13 identified that the resident scored a BIMS of 12 indicating moderately impaired cognition. The CAA reported the resident complained of pain in his/her hips and low back. The resident requested Percocet (narcotic prescribed pain medication) and stated the resident will ask for the medication again 30 minutes after he/she received it.

Resident # 16's care plan included a risk for pain problem dated 1/16/13 that identified the resident had a recent left hip repair and history of a status post right hip repair with a stated goal of: the resident will receive adequate pain relief for optimal comfort to participate in ADLs, directing staff to offer a change of position to help the resident discomfort.

The resident's physician orders included the following PRN (as needed) medications to treat pain:
* Acetaminophen 325 mg orally with Percocet as

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needed, both medications combined not to exceed 3000 mg in 24 hours
* Percocet 5/325 mg orally every 4 to 6 hours as needed for pain not to exceed 3000mg Acetaminophen
* Bio freeze as needed to affected areas

The Medication Administration Record revealed the staff failed to obtain follow-up results for effectiveness after administering the pain medication to the resident on the following dates: 10/2/13 twice, 10/7/13 twice, 10/10/13 once, 10/12/13 once, 10/14/13 once, 10/15/13 once, 10/16/13 once, 10/17/13 twice, 10/19/13 once, and 10/20/13 twice.

Pharmacist consultant X reports between September 2013 through October 2013, revealed he/she notified administrative nursing staff A on multiple reports that nursing staff failed to consistently monitor for effectiveness of as needed medications.

During an observation on 10/16/17 at 09:45 a.m. direct care staff I assisted the resident to and from the bathroom. The resident verbalized complaints of pain to his/her hips and knees, multiple times. Staff I informed the resident he/she would notify the nurse of the request for pain medication.

During an observation on 10/16/13 at 3:50 p.m. direct care staff P assisted the resident to and from the bathroom, he/she made soft moaning noises and expressed facial grimaces. The resident verbalized to staff P that his/her hips hurt. Staff P stated she would notify the charge nurse and verify if pain medication could be given,

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During an interview on 10/17/13 at 3:00 p.m., Licensed Nursing Staff R stated the resident frequently made complaints of pain. As the Charge Nurse he/she administered narcotic pain medication and other medicated products like Biofreeze. After he/she administered a PRN medication, the nurse should follow up with the resident for effectiveness.

During an interview on 10/21/13 4:00 p.m. Consultant X stated he/she notified administrative nursing staff A, of irregularities at different times throughout the previous 12 months. Consultant X referred to an irregularity by nursing staff not consistently monitored for effectiveness of an as needed medication after administration. He/she stated resident #16 medication administration record was an example of the inconsistency.

The facility's 5/14/12 Administration of Medication policy stated PRN (as needed) medications are charted with initials and time on the MAR (medication administration record). In addition, record the date, time, medication given, route, dose, nurse's initials, reason and effect of PRN on the PRN part of the MAR.

The facility failed to act upon Consultant X's recommendations for correction of irregularities related to monitoring the effectiveness of resident #16's pain medication.

- Resident #8's 9/25/13 physician's orders included a diagnosis of Multiple Sclerosis (progressive disease of the nerve fibers of the brain and spinal cord).

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Resident #8's 8/16/13 Annual MDS (Minimum Data Set) Assessment reported that the resident understood others, made him/herself understood, and had no cognitive impairment. The MDS reported he/she had moderate depression and no behaviors. The resident experienced pain that he/she rated as a 6 out of 10 that affected his/her sleep and daily activities.

Resident #8's Mood, Psychotropic Drug Use, and Pain CAA (Care Area Assessment) summaries reported the resident felt that he/she had little energy and trouble sleeping and saw a licensed social worker on a regular basis. The resident complained of occasional headaches during the observation period. The resident received multiple medications for pain, including Robaxin for muscle spasms and Gabapentin for nerve pain on a regular basis and Tylenol and Ultram as needed.

Resident #8's 8/28/13 care plan informed staff that the resident experienced pain due to multiple back surgeries, had right hip pain, and experienced pain from the diagnosis of Multiple Sclerosis. Interventions included having the resident rate his/her pain from 0 as none to 10 as the worst, give pain medications as ordered, and monitor the response and effectiveness of the pain medications.

Review of the resident's physician's orders included orders for as needed pain medication:
* Norco 5/325 mg (milligrams) 1 tablet orally every 6 hours as needed for pain with a start date of 9/25/13
* Ultram 50 mg orally every 6 hours as needed for pain, give one tablet for pain rated between 1 -

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5 and 2 tablets for pain rated between 6 and 10 with a start date of 8/28/12
* Tylenol 325 mg orally every 4 to 6 hours as needed, give one tablet for pain rated between 1 - 5 and 2 tablets for pain rated between 6 - 10

Review of the resident's September 2013 MAR (Medication Administration Record) revealed that staff documented as needed medication on the back of the sheet with a space to document how effective the medication treated the issue. Staff documented that the resident received Tylenol 325 mg 2 tablets 62 times and staff failed to monitor the effectiveness of Tylenol 22 of the 62 times. The resident received Norco 2 tablets 13 times and staff failed to monitor the effectiveness 1 of the 13 times.

Review of the resident's October 2013 MAR revealed staff gave the resident Norco 2 tablets 49 times and staff failed to monitor the effectiveness of Norco 14 of the 49 times. The resident received Tylenol 4 times and staff failed to monitor for the effectiveness 2 of the 4 times.

Review of resident #8's consulting pharmacist's monthly medication review revealed on 2/2/13, 3/8/13, and 9/14/13, the pharmacist consultant reported irregularities to the director of nursing that staff failed to document the effectiveness of multiple as needed medications throughout the months he/she reviewed.

During an observation on 10/15/13 at 4:31 p.m., resident #8 walked independently in the hallway while he/she used a walker, took slow, determined steps, and stopped after a few steps taking deep breaths.

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During an interview on 10/21/13 at 3:59 p.m., Consultant X reported that he/she did report irregularities to the Administrative Nursing Staff A at different times throughout the last 12 months about staff not monitoring the effectiveness of as needed medications, such as resident #8.

The facility failed to act upon the consultant pharmacist's reports of irregularities that staff failed to monitor the effectiveness of as needed medications for resident #8.

- Resident #38's 8/28/13 physician's orders included diagnoses of anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), vascular dementia (progressive mental disorder characterized by failing memory, confusion) with delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and gout (inflammation of the joints).

Resident #38's 7/17/13 Significant Change of Status MDS (Minimum Data Set) Assessment reported the resident usually understood others, made him/herself understood, and had severely impaired cognition. The resident had fluctuating inattention, disorganized thinking, and altered levels of consciousness. The resident experienced mild depression and delusions. He/she displayed disruptive behavior not directed toward others 1 to 3 days of the 7 day observation period that interrupted activities and the living environment of others. The resident experienced no pain and received antipsychotic, antianxiety, and antidepressant medications for 7 of the 7 observation days.

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Resident #38's 7/23/13 Psychotropic Drug Use CAA (Care Area Assessment) summary reported that the resident received Seroquel (an antipsychotic medication) for hallucinations and inappropriate behavior toward staff and Pristiq for depression.

Resident #38's care plan, last reviewed on 7/24/13, informed staff that the resident transferred to a geriatric psychiatric hospital on 6/24/13 and returned to the facility on 7/11/13. The care plan informed staff that the resident was at risk for elopement and instructed staff to go on walks outside in good weather or invite the resident to watch football on television. The care plan indicated the resident experienced pain at time due to gout, give pain medications as needed and monitor the effectiveness of the medication, and that the resident will not always verbalize his/her pain so watch for facial expressions.

Review of the resident's physician's orders included orders for:
* Ativan 1 mg orally every 8 hours as needed for agitation with start date of 3/24/13
* Ativan 1 mg/ml topically as needed every 4 hours for agitation with a start date of 7/11/13
* Lortab (a pain medication) 5/500 1 tablet orally every 4 hours for pain with a start date of 8/7/13

Review of resident #38's September 2013 MAR (Medication Administration Record) revealed that staff documented as needed medications on the back of the sheet with space provided to monitor results. Staff gave the resident Ativan orally 26 times and failed to monitor the effectiveness of the medication 8 of the 26 times. Nursing staff documented that the resident received Lortab 8

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times and failed to monitor the effectiveness 2 of the 8 times.

Review of the resident's October 2013 MAR revealed that staff gave the resident Ativan 16 times and failed to monitor the effectiveness 4 of the 16 times. Staff documented they gave the resident Lortab 16 times and failed to monitor the effectiveness 4 of the 16 times.

Review of resident #8's consulting pharmacist's monthly medication review revealed on 8/4/13 and 9/14/13, the pharmacist consultant reported irregularities to the director of nursing that staff failed to document the effectiveness of multiple as needed medications throughout the months he/she reviewed.

During an observation on 10/15/13 at 2:41 p.m., resident #38 ambulated independently, spoke in a loud voice, and while putting on his/her coat he/she told Direct Care Staff V he/she was going to the library. Staff V invited the resident to walk with him/her outside and reported to other staff he/she and resident #38 were about to leave the facility to take a walk. After Staff V entered the code to exit the south facing/north hallway door, resident #38 pushed open the door and refused to move unless Staff V walked back into the building. Activity/Social Service Staff Q walked next to resident #38 and invited him/her to walk outside while Staff V entered the building. Resident #38's demeanor calmed as Staff Q walked with the resident outside.

During an interview on 10/21/13 at 3:59 p.m., Consultant X reported that he/she did report irregularities to Administrative Nursing Staff A at different times throughout the last 12 months

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F 428	Continued From page 56 about staff not monitoring the effectiveness of as needed medications, such as his/her review of resident #38's MAR. The facility failed to act upon the consultant pharmacist's reports of irregularities that staff failed to monitor the effectiveness of as needed medications for resident #38.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		

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hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 39 residents.

Based on observation, interview, and record review, the facility failed to process linens as to prevent the spread of infections for all residents and failed to prevent the transmission of disease and infection during medication administration.

Findings included:

- During a tour of the facility's laundry on 10/21/13 at 8:20 a.m., the facility had one domestic laundry washer and two small sized commercial washers in use.

During an interview on 10/21/13 at 8:20 a.m., Housekeeping/Laundry Staff E reported that he/she washed all personal resident laundry. Staff E stated he/she followed the washing instructions on the resident's clothing to determine what temperature to wash the laundry. Staff E stated if the item needed to be washed in cold or warm water, he/she poured TMA quaternary cleanser into a small, unmarked cup approximately 3/4 inch high for a full load of laundry and placed the unmeasured cleanser into the washer.

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Review of the TMA quaternary label instructed to use 1 ounce for 5 pounds of dry laundry, 2 ounces for 6 to 10 pounds of dry laundry, and 3 ounces for 11 to 20 pounds of dry laundry.

During an observation on 10/21/13 at 8:23 a.m., Staff E poured the unmeasured amount of quaternary cleanser into a measured cup and noted the cup filled to a level between the 1/2 ounce and 1 ounce mark. A label inside the small commercial washer indicated "load size 16 pounds".

During an interview on 10/21/13 at 8:24 a.m., Staff E verified he/she failed to sanitize residents clothing when he/she failed to use the instructed amount of 3 ounces of quaternary cleanser for a full load of laundry (approximately 16 pounds).

The facility failed to process resident's linen/laundry when staff failed to follow manufacturer's instructions for a quaternary cleanser while washing resident items in cold or warm water.

- During an observation on 10/15/13 at 8:38 a.m., Licensed Nursing Staff S dropped resident #27's Lexapro tablet on to the medication cart which had multiple small crumbs and debris. Staff S pushed the tablet with his/her bare index finger into a medication cup that he/she laid on it's side and touched the rim of the medication cup on the medication cart. Staff S placed the tablet into a pill splitter with his/her bare hand then placed half of the tablet back into the contaminated medication cup. At 8:39 a.m., Staff S gave resident #27 medications in the contaminated medication cup, including the contaminated half

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F 441	Continued From page 59 tablet of Lexapro, and resident #27 put the medication cup up to his/her lips while swallowing the pills. During an interview on 10/15/13 at 11:50 a.m., Licensed Nursing Staff S stated he/she should not have touched the resident's medication with his/her bare hands and should have destroyed the tablet after it dropped on the medication cart. The facility's 11/9/06 "Administration of Medication" lacked instructions related to dropped medications or how to handle pills that needed to be split. The facility failed to ensure that staff prevented the spread of infection when staff touched a resident's pill with their bare hands.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		

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except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 39 residents.

Based on observation, interview, and record review, the facility failed to develop and implement an action plan to correct identified quality deficiencies in the QAA (Quality Assessment and Assurance) committee meetings.

Findings included:

- Review of the roster of QAA committee meetings revealed that the facility met on 8/22/12, 12/18/12, 2/27/13, 5/22/13, and 8/28/13.

During an interview on 10/21/13 at 12:01 p.m., Direct Care Staff C reported that Administrative Nursing Staff A, Physician O, Activity/Social Service Staff Q, Administrative Nursing Staff B, Housekeeping/Maintenance/Laundry Staff D and E, and him/herself attend quarterly QAA meetings. Staff C reported that he/she brings reports of each quality area such as what percentage of residents had falls or weight loss within the last quarter but did not discuss individual residents to develop an action plan to reduce the occurrence of falls or weight loss.

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F 520	Continued From page 61 - Based on observation, interview, and record review, the facility failed to ensure 1 resident reviewed for physical restraints remained free of physical restraints not required to treat the resident's medical symptoms as cited at F 221. - Based on observation, interview, and record review, the facility failed to maintain a sanitary and comfortable interior (dust accumulation on bathroom ceiling vents in 5 resident rooms on the east hallway and 1 resident room on the west hallway with gouges in the walls) as cited at F 253. - Based on observation, interview, and record review, the facility failed to review/revise 2 of the 12 residents' comprehensive care plans related to falls as cited at F 280. - Based on observation, interview, and record review, the facility failed to provide the necessary care and services (pain management) to attain or maintain the highest practical physical, mental, and psychosocial well-being for 1 of 2 residents sampled with pain issues as cited at F 309. - Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents/falls for 2 of 3 residents sampled for accidents related to falls as cited at F 323. - Based on observation, interview, and record review the facility failed to ensure the resident environment remained free from potential accidents with the use of bed rails with large gaps that posed a potential for entrapment for 1 sampled resident as cited at F 323.	F 520		

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F 520	Continued From page 62 - Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accidents/hazards for 19 independently mobile cognitively impaired residents when staff stored potentially hazardous chemicals in areas accessible to residents as cited at F 323. - Based on observation, interview, and record review, the facility failed to ensure that 1 of the 3 sampled residents maintained acceptable parameters of nutritional status such as body weight when staff failed to follow recommendations from the consulting registered dietician as cited at F 325. - Based on observation, record review, and interview the facility failed to ensure 3 of 5 residents sampled did not receive unnecessary drugs when the facility failed to monitor for effectiveness of medications as cited at F 329. - Based on observation, interview, and record review, the facility failed to serve food under sanitary conditions (use of contaminated gloves while assisting residents with eating) as cited at F 371. - Based on observation, record review, and interview the facility failed to ensure the consultant pharmacist reported irregularities to the attending physician and director of nursing, and these reports were acted upon related to monitoring of effectiveness of as "needed" medications for 3 of 5 sampled residents as cited at F 428. - Based on observation, interview, and record	F 520		

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F 520	Continued From page 63 review, the facility failed to process linens as to prevent the spread of infections for all residents and failed to prevent the transmission of disease and infection during medication administration as cited at F 441. The facility failed to develop and implement an action plan to correct identified quality deficiencies in the QAA committee meetings.	F 520		